

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 002869	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2012
NAME OF PROVIDER OR SUPPLIER SOUTHERN INDIANA ENDOSCOPY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 825 UNIVERSITY WOODS DR STE 3 NEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 30405 Facility Number: 002869</p> <p>Type of Survey: State Licensure Off Site AAAHC Accreditation Survey</p> <p>Date of AAAHC On Site Survey - ASC full survey April 26-27, 2012</p> <p>Date of ISDH off site review - September 11, 2012</p> <p>Reviewer/Surveyor - Deborah Franco RN, PHNS</p> <p>Based on review of the April 26-27, 2012 AAAHC Accreditation Survey Report, it has been determined that Southern Indiana Endoscopy Center meets the requirements for ASC Licensure in Indiana.</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

XIZ811

If continuation sheet 1 of 1